DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ĭ .		ONSTRUCTION 00	COMPI		
711.12112.11	o. condenon	155561		LDING	<del></del>	09/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER				JACKSON ST		
		& REHABILITATIVE CENTER		OAKLA	AND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
F0000	REGULATORT OR	LSC IDENTIFTING INFORMATION)		IAG			DAIL
1 0000							
			FC	0000			
	This visit was for	r the Investigation of					
	Complaint IN000	095041.					
	_						
	Complaint IN000	095041 Substantiated,					
	Federal/State def	iciency cited at F240.					
	Survey dates:						
	September 14 and	d 15, 2011					
	Facility number:						
	Provider number						
	AIM number: 10	0273920					
	Survey teem:						
	Survey team:	ra DN					
	Anne Marie Cray	/S, KIN					
	Census bed type:						
	SNF/NF: 78						
	Total: 78						
	101111. 70						
	Census payor typ	oe:					
	Medicare: 12						
	Medicaid: 46						
	Other: 20						
	Total: 78						
	Sample: 7						
	1	also reflects state findings					
	cited in accordan	ce with 410 IAC 16.2.					
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

72LK11

Facility ID:

000327

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	(X3) DATE SURVEY  COMPLETED			
	155561			09/15/2011			
ROVIDER OR SUPPLIER							
AMARITAN HOME &	REHABILITATIVE CENTER	OAKLAND CITY, IN47660					
		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
*		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE			
Quality review completed on September 19, 2011 by Bev Faulkner, RN							
manner and in an emaintenance or en	environment that promotes hancement of each						
Based on i	interview and	F0240	The creation and submission of this plan of correction do	0 0 7 2 0 7 2 0 1 1			
record rev	iew, the		not constitute an admissior	n by			
			set forth in the statement of				
•	•		defiencies or any other violation of regulation. This				
		provider respectfully requests that the 2567 be considered the letter of credible allegation and		I the			
	A facility must care manner and in an emaintenance or enresident's quality or Based on it record rev facility fai care which	OVIDER OR SUPPLIER  MARITAN HOME & REHABILITATIVE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Quality review completed on September	OVIDER OR SUPPLIER  MARITAN HOME & REHABILITATIVE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Quality review completed on September 19, 2011 by Bev Faulkner, RN   A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.  Based on interview and record review, the facility failed to provide care which enhanced the	OVIDER OR SUPPLIER  MARITAN HOME & REHABILITATIVE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR IS CIDENTIFYING INFORMATION)  Quality review completed on September  19, 2011 by Bev Faulkner, RN  A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.  Based on interview and record review, the facility failed to provide care which enhanced the resident's quality of life.			

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Event ID:

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If continuation sheet

Page 2 of 17

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER  (VA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (PACH DEFICIENCY MUST BE PERCEDED BY FILL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  In that a resident residing on the Alzheimer's Unit was transferred to a different room causing psychosocial distress for the resident and resulting falls and an increase in medications for disruptive behavior, for 1 of 3 residents reviewed who had transferred to different rooms, in a sample of 7. Resident B  Findings include:  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST  SCANLAND CITY, INA7660   (XS)  PREFIX TAG  FREFIX TAG  FREF	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN47660  (X4) ID PREFIX TAG  IN THAT A resident residing on the Alzheimer's Unit Was transferred to a different room causing psychosocial distress for the resident and resulting falls and an increase in medications for disruptive behavior, for 1 of 3 residents reviewed who had transferred to different rooms, in a sample of 7. Resident B  Findings include:  SUMMARY STATEMENT OF DEFICIENCES 231 N JACKSON ST DAKE OF OBSECTION OAKLAND CITY, IN47660  (X5) PREFIX TAG  PROVIDER R.NOF COBRECTION CACHORS WICH CACHORS W	ANDILAN	or correction		1			
231 N JACKSON ST   OAKLAND CITY, IN47660   OAKLAND C				B. WIN		ADDRESS CITY STATE ZIPCODE	
CAMARITAN HOME & REHABILITATIVE CENTER   CAKLAND CITY, IN47660	NAME OF P	ROVIDER OR SUPPLIER			1		
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Findings include:  be affected by the alleged deficient practice. Resident's who have had room moves in the past 30 days have been reviewed to ensure psychosocial well being.		sample of	7. Resident D				l l
Findings include:  deficient practice. Resident's who have had room moves in the past 30 days have been reviewed to ensure psychosocial well being.						T	al to
30 days have been reviewed to ensure psychosocial well being.		Findings i	noludo.				who
ensure psychosocial well being.		rmumgs	iiciuuc.				
						_	
On 9/14/11 at 9:55		On $\Omega/14/1$	11 at 0.55				- 1
in serviced and a post test		OH 3/14/	11 at 7.33				
A.M., the Alzheimer's performed on transfer/room move policy by Nurse Consultant by		A.M., the	Alzheimer's			•	
Linit Manager indicated 9-26-2011. Potential room						9-26-2011. Potential room	´
		Unit Manager indicated			_	)   	
Resident B had recently discussed with Interdisciplinary Team prior to move. SSD /MCF		Resident I	B had recently				- 1
will monitor for adjustments and			Ž				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155561	B. WIN			09/15/20	J11
NAME OF I	PROVIDER OR SUPPLIEF	\ {		1	ADDRESS, CITY, STATE, ZIP CODE		
COODS	AMADITAN HOME	& REHABILITATIVE CENTER		1	IACKSON ST ND CITY, IN47660		
				L	ND CITT, IN47000		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	<b>\</b>			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	been trans	eformed to			report to IDT team. What		
	been trans	sierreu to			measures will be put into p		
	another ro	om to			or what systematic change will be made to ensure that		
		da4a a massiles			deficient practice does not	· · ·	
	accommo	date a newly			recur;Resident's will not be		
	admitted 1	married couple.			moved/transferred unless it i		
					the best interest of the reside Interdisciplinary Team will dis		
					all room changes prior to		
	The clinic	cal record of			movement. And documentat		
					will be placed in chart to clar and identify reason for room	iiy	
	Resident	B was reviewed			change. Interdisciplinary Tea		
	on 9/14/1	1 at 10:20 A.M.			will monitor residents for nee		
					transfer. Transfer will only or one of the following condition		
	Diagnoses	s included, but			are met. Transfer is necessa	ry for	
	were not 1	limited to,			medical reasons, as judged l Physician. Transfer is neces		
		•			for the welfare of the residen	-	
	Dementia	•			other persons. Resident , or		
					deemed incompetent Family request. How the corrective		
					action(s) will be monitored		
	A "Intra-F	acility			ensure the deficient practic		
	Transfer N	Notice of Room			will not recur,i.e.,what qual	- 1	
					assurance program will be into place; Social Service	put	
	Change,"	dated 7/2/11,			Director and Memory Care		
	indicated:	"1 An			facilitator will oversee room changes to assure compliand		
					and will report any adverse		
	ıntra-facil	ity transfer is a			from to Continuous Quality		
					Improvement committee overseen by Executive Direct	tor	
	change of beds or rooms				CQI committee will immediat		
	within a certified				intervene to ensure psychos	ocial	
	sectionof the facility.				needs are met. By what date systematic changes will be		
		of the facility.			completed.September 26 th		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155561		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE S COMPL 09/15/2	ETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  231 N JACKSON ST  OAKLAND CITY, IN47660				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	2. In India	ına, an			2011.		
	intra-facility transfer can						
	be made of necessary reasons; of necessary of the resident manufacture at large days before expected, a. Individual health word endangered Resident's improves Resident's resident re	for medical r b. Is for the welfare dent or others. tra-facility required, the nust be given east two (2) re relocation is except when: ual(s) safety or uld be ed; b. health or: 3.			Facilitty# 000327 Provider # 155561 Survey Eventt ID 72LK11 Survey Datte Septtembe£5 tth , 2 Addendum tto original POC  Please explain your process ofi monittoring fior tthe residentt's v have had room changes. Residentt's will be monittored an assessed fior disttress relatted tto change fior72 hours. All shifis will documentt adjusttmentt or lack of adjusttmenttand IDT tteam will dettermine ifi adjusttmentt was successfiul and ifi so will ttake ofi conttnuous monittoring Social Service Directtor and Memory Cafacilittattor will monittor ongoing intermittentt adjusttmentt and of psychosocial issues.  Whatt process will be in place to dettermine compliance Will tthe resultts be reviewed by your Quafeview Committee? Att whatt powill monittoring be disconttnued CQI ttool will be uttlized tto monicompliance. Conttnuous Qualitty Improvementt Committee will recQI datta, fior compliance months and quartterly tthereafior ttwo quartters fidocumenttal	who d room offi re g fior r litty intt ttor wiew only X fier	
	medicai n	eeds require			is nott presentt and actton plan v		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 00	(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER		1	ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETIO DATE	)N
	immediate	e transferThis			be developed. CONTINUOS QUALIT	,	
	is to infor	m you that it is			IMPROVEMENT TOOL RC CHANGES	ОМ	
	necessary	to move you					
	from: Roc	om [number] to			Residentt whom experienced a r move	oom	
	Room [nu	mber] on July			 Datte Move		
	2, 2011. T	he reason for			Occurred		
	this transfer is: for the benefit of the resident. I				Room moving		
					tto		
	do waive	my right to			Roommatte nottfied		
	forty-eigh	t (48) hours			Reason fior Room		
	notice. I d	o waive my			Move		
	right to a	relocation					
	planning						
	conferenc	eLegal					
	Represent	ative [name]					
	this is to c	confirm that					
	you were	advised by					
	telephone	on July 2,			IDT tteam Discussed room chang documentt in	e	
	2011 of th	ne need for the			chartt		
	above resident to change				Family Nottfied and paperwork		
					signed		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155561		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00		DATE SURVEY COMPLETED 1/15/2011	
	PROVIDER OR SUPPLIER	L & REHABILITATIVE CENTER	Б. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	rooms. Da	ate [unsigned]			Residentt monittored each sh	fi fio <b>7</b> 2	
	Signature	of Legal			hours		
	Representative [unsigned]"  Social Progress Notes included the following notations:				Documenttatton reviewed		
					Documenttatton witthim2 hou Social Service Nottes	rs in	
					Montthly fiollow up firom SSE fior3 montths	or MCF	
	7/2/11 [un [with] res this day to room mov to room [n	itimed]: "Spoke [resident] on o inform her of we. Res moved number]. Res			Quartterly fiollow up firom SS fior ttwo quartters		
	upset abou	ntimed]: "Res ut room move. pts to go into					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		(X2) MU  A. BUILL  B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER		231 N J	ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	former roo	om and resists					
	redirection. Spoke [with]						
	res on this	date, res did					
	not respor	nd when asked					
	if she was	upset about					
	new room	. Will cont. to					
	monitor."						
	Nurses Notes included the following notations:  7/4/11 at 9:15 P.M.: "Res had behavior @ [8:00 P.M.] such as yelling loudly when res was taken to new roomRes angry d/t [due to] fact she can't enter her old rm						
		Res doesn't d why she can't					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155561		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 09/15/2	LETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER		231 N J	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	enter her	old roomRes					
	hitting pir	nching					
	staffRes	yelling woke					
	other resid	dents et [and]					
	caused the	em to be upset.					
	Explained	to res that she					
	has new roomRes						
	agreed to	sit in chair by					
	old rm"	1					
	7/6/11  at 6	5:15 P.M.: "Res					
	entered he	er old rm et					
	would not	leave when					
	asked. Re	s began					
	hitting/pir	nching/scratchi					
	ng/biting	this nurse as I					
	tried to ex	plain to res she					
	had new r	oom et try to					
	get res ou	t of other					
	residents 1	rm. Res also hit					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 09/15/2	LETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  231 N JACKSON ST  OAKLAND CITY, IN47660				
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	CNA who	was assisting					
	this nurse	in removal of					
	res from v	wrong rm. MD ."					
	dated 7/6/ "Res wou redirection when attended the out of room. Resconfusion Staff spok and expla	ogress Notes, '11, indicated, Id not allow In from staff Inpting to assist Ther former Is displaying I about move. Ite [with] res I ined new room I ined her to locate I inc."					
-		an's order, 11, indicated to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 09/15/2	LETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER		231 N J	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	increase I	Depakote					
	[medication	on given for					
	behaviora	l symptoms]					
	from 125	mg every					
	morning t	o 250 mg every					
	morning.						
	An Interd	isciplinary					
	Team [ID'	T]Progress					
	Note, date	ed 7/15/11,					
	indicated,	"She was					
	recently n	noved to room					
	across the	hall from her					
	old room	which she had					
	been in fo	r over 2 years.					
	She was g	oing to enter					
	her old ro	om when					
	resident, v	who resides in					
	this room	closed door @					
	this time of	causing res to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 00	(X3) DATE : COMPL		
		155561	B. WIN	IG		09/15/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER			ND CITY, IN47660		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
	lose her ba	alance et [and]					
	fall"						
	An Interdi	isciplinary					
		gress Note,					
	dated 7/18	3/11, indicated,					
	"IDT revi	ewed incident					
	occurring	on 7/17/11 @					
	1605 [4:0:	5 P.M.] when					
	resident w	as starting into					
	her previo	ous room and					
	current res	sident was					
	starting to	exit room.					
	They colli	ded causing					
	this reside	ent to fall"					
	A therapy	note, dated					
	7/18/11, ii	ndicated, "ST					
		erapy] to eval					
	- I	for orientation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		(X2) MULT  A. BUILDII  B. WING		NSTRUCTION  00	(X3) DATE S COMPL 09/15/2	ETED	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  231 N JACKSON ST  OAKLAND CITY, IN47660				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	with the p	t [patient]					
	having red	cent room					
	move [and	d] difficulty					
	locating n	ew room"					
	A Social Progress Note,						
	dated 8/9/11, indicated,						
	"[Name of psychiatrist]						
	saw res on 8-8-11 and						
	ordered to [increase]						
	Depakote to 250 mg po						
	[by mouth] tid [three						
	times daily] after meals						
	d/t [due to] [increased]						
	behaviors."						
	Nurses No	otes continued:					
		4:47 A.M.:					
	"Contin	ues to have					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		IDENTIFICATION NUMBER:	A. BUI	LDING	NSTRUCTION  00	(X3) DATE S COMPL 09/15/2	ETED
NAME OF PROVIDER OR SUPPLIER			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE  ACKSON ST	1 00/10/2	-
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	confusion	about her					
	room sinc	e she had a					
	room char	nge the First					
	part of Jul	y. Re-directed					
	to her roo	m"					
	An IDT note, dated						
	8/24/11, indicated,						
	"She had 2 falls last						
	month perhaps d/t room						
	move"						
	A Physicia	an's Progress					
	Note, dated 8/30/11,						
	indicated, "Her room						
	was move	d recently and					
	this did m	ake a					
	difference	, but she seems					
	to be doin	g much better					
	now"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		A. BUII B. WIN	LDING	NSTRUCTION  00	li i	E SURVEY PLETED 72011	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  231 N JACKSON ST  OAKLAND CITY, IN47660				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	An IDT no 9/13/11, in was attempted the door to room. She balance, for become in confused a move III for possib move"  On 9/14/1 P.M., during with the Annual Property of the possib move"	ote, dated ndicated, "res pting to open o her previous e lost her fellRes has acreasingly since her room OT will review		TAG	DEFICIENCY)		DATE
		Resident B o move due to sion of a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER		ND CITY, IN47660	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	married co	ouple." The			
	Alzheime	r's Unit			
	Facilitator	indicated the			
	resident d	id have			
	"issues" w	hen she first			
	changed r	ooms, and that			
	she hoped	to eventually			
	move her back into her				
	old room.				
	This feder	ral tag relates to t IN00095041.			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155561		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/15/2011	
	PROVIDER OR SUPPLIER		STREET 231 N 3	ADDRESS, CITY, STATE, ZIP CODE  JACKSON ST	
		& REHABILITATIVE CENTER		ND CITY, IN47660	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE